The information below is a list of important fields on the new UB-04 claim form for Providers that are billing with their NPI #. All fields that are not listed are not needed to process a claim for Montana Medicaid.

Client Has Medicaid Only

UB-04		
Field #	Field Title	Instructions
1*	Provider's Physical Address	Enter Provider's Physical Address with a 9-digit ZIP.
3a**	Control Number	Client's control used by provider
4*	Bill Type	Enter Billing Code
6*	Statement Covers Period	The beginning and ending service dates of the period included on this bill.
7**	Unlabeled field	Passport (beg w/99) **OR** Override Indicator (beg. w/alpha character)
8b*	Patient's Name	Enter Client's Name as seen on client's Montana's Healthcare Programs information
12-15**	Admission	For inpatient used enter the admission date, hour, type and source
17*	Patient Status	A code indicating client discharge status as of the ending service date of the period covered on this bill.
18-28**	Condition Codes	condition codes that are applicable A4 and B3
42*	Revenue Codes	A code which identifies a specific accommodation, ancillary service or billing calculation.
43**	Revenue Description NDC coding	Enter revenue description Enter NDC if drugs were administered
44*	HCPCS/ RATE/ HIPPS CODE	Outpatient: coding for HCPCS / NDC Inpatient: Not required
45**	Service Dates	Outpatient: Enter dates of service for each line item with revenue code Inpatient: Not required
46*	Service Units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation day, miles, pints of blood, etc. Must be appropriate for the procedure code, if listed.
47*	Charges	Enter charges (covered and non-covered) for each line containing a revenue code.
Line 23*	Creating Date	Enter the Date the claim was created (bill date)
50*	Payer Name	Not required if only Montana Healthcare Programs are billed
54*	Prior Payments	If applicable
56*	NPI number	Enter billing provider's NPI number
58*	Insured's Name	Enter name of the individual in whose name the insurance is carried
60*	Insured's ID	Montana Healthcare Programs ID of the individual in whose name the insurance is carried.
NOTE	All information related to Montana's Healthcare Programs needs to be on the corresponding line (A,B,C) in fields 50, 54, 56, 57, 58, and 60.	
63**	Treatment Authorization	Enter a Prior Authorization number if applicable to the service
67 A-Q*	Diagnosis Code	Enter principal diagnosis code
69**	Admitting Diagnosis	Inpatient: Enter diagnosis identified at the time of hospitalization
72**	EMG	Emergency Code
73**	Unlabeled	Cost Share Indicator
74 a-e**	ICD-9 Procedure Code	Inpatient only: Procedure Codes
76*	Attending Provider	1st box Attending Provider NPI # 2nd taxonomy code ZZ = Id Qualifier
77-79**	Operating and Other Providers	1st box Operating/Other Provider NPI # 2nd box taxonomy code ZZ=Id Qualifier.
81cc*	Taxonomy	Enter Billing Providers Taxonomy number.
Signature	**Not needed.**	**UB-04 Does not have an area**

*Required Fields
**Conditional Fields (Required if Applicable)

Medicaid Only

Required Fields are Highlighted

1 Take Time Medical Center 104 Time Square Helena, MT 59601-0104	3a PAT. CNTL # 4806 b. MED. REC. # Grisw97531 4 TYPE OF BILL 131 5 FED. TAX NO. 6 STATEMENT COVERS PERIOD FROM 02/01/07 THROUGH 02/04/07 7 9912345

8 PATIENT NAME a Pat.'s ID b Griswold, Clark	9 PATIENT ADDRESS a 1313 Mockingbird Lane. Metropolis. MT 59601-1313
10 BIRTHDATE 03/26/30	11 SEX M
12 ADMISSION DATE 02/01/07	13 HR 11
14 TYPE	15 SRC 1
16 DHR	17 STAT 01
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE
30	
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH
37	

38
Griswold, Clark
1313 Mockingbird Lane
Metropolis, MT 59601-1313

39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
a		
b		
c		
d		

42 REV. CD.	43 DESCRIPTION NDC	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	Room and Board			4	3200 00		
259	Other Pharmacy N4 00026064871 GR 150			1	620 00		
270	General Class Medical/Surgical Supplies			110	583 00		
300	General Class Laboratory			4	500 00		
	PAGE ____ OF ____		CREATION DATE 04/01/07	TOTALS	333 60		

50 PAYER NAME Medicaid	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS
55 EST. AMOUNT DUE	56 NPI 1876543210	57 OTHER PRV ID		

58 INSURED'S NAME Griswold, Clark	59 P REL	60 INSURED'S UNIQUE ID 123456789	61 GROUP NAME
62 INSURANCE GROUP NO.			

63 TREATMENT AUTHORIZATION CODES 10987645321	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 780.39 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX 540.0	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c
73			

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE
75		

76 ATTENDING	NPI 1766554433	QUAL ZZ	363PL000X
LAST Munster	FIRST Herman		
77 OPERATING	NPI 0123456789	QUAL zz	363LP000X
LAST Adams	FIRST John		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS

81CC a	363LP0222X
b	
c	
d	

OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Boarder Colors
- Client Fields
- Provider Fields
- Billing Fields

The information below is a list of important fields on the new CMS 1500 claim form for providers that bill using a NPI # . All fields that are not listed are not needed to process a claim for Montana Medicaid. This table will expire 10/01/2007.

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Medicaid Montana's Healthcare Programs information
10d, *	Client's Medicaid ID	Enter the client's Medicaid Montana Healthcare Programs ID number as it appears on the client's Medicaid Montana's Healthcare Programs information.
1a, 9a, 11**	Clients Medicaid ID	If Client's ID is not located in 10d these three fields are searched for the number
Provider Information		
17a **	Referring Provider's Medicaid/ Passport #	Enter Referring Provider's 2-digit ID qualifier (1D) followed by Medicaid Montana's Healthcare Programs number for atypical providers #. Enter Referring Providers Passport number if a Passport client
17b **	Referring Provider's NPI #	Enter Referring Provider's NPI #
24i shaded*	ID Qualifier	Enter **1D** as the Medicaid or Atypical qualifier or **ZZ** for the Taxonomy qualifier (not required during contingency period)
24j	Taxonomy Code	Enter the Taxonomy code for the rendering provider
24j shaded *	Medicaid/ Taxonomy #	Enter Medicaid Number, Atypical provider number or Taxonomy Number (not required during contingency period
24j *	NPI Number, Rendering Prov	Enter NPI Number for the rendering provider.(not required during contingency period
31*	Signature and Date	Enter Signature and Date
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing providerif applicable.
33b*	TaxonomyMedicaid # Atypical Provider #	Enter the 1D qualifier (ZZ) and the billing provider's Medicaid number.taxonomy code
Billing Information		
21.1 – 21.4*	Diagnosis codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency Indicator if applicable
24d*	Procedure Code	Enter the procedure code used/ Enter Modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1,2,3,or4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field

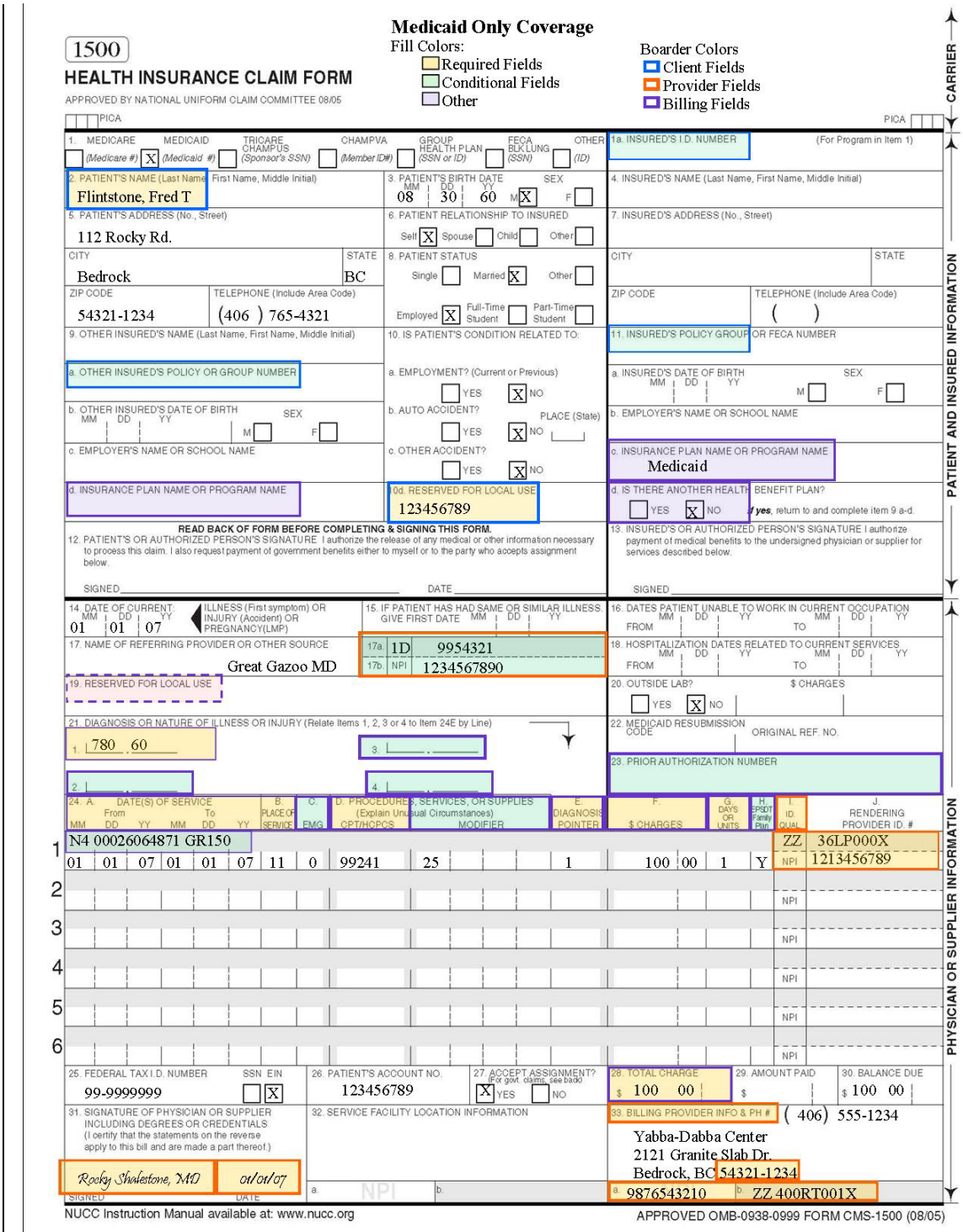
** = Conditional (Required if applicable)

Important Dates

June 1: ACS only accepts new claim forms for both CMS 1500 and UB-04

Present - Oct 1: Providers may use both Medicaid and NPI #. Refer to the table to recognize where to add each ID number.

After - Oct 1: Only new claim forms are accepted.
Only NPI numbers and Taxonomy codes are accepted for billing providers.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Boarder Colors
- Client Fields
- Provider Fields
- Billing Fields

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 30 60 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY STATE

ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY 01 01 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a. ID 9954321

17b. NPI 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 780.60 3. ____.____

2. ____.____ 4. ____.____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N4 0002064871 GR150														ZZ	36LP000X
1 01	01	07	01	01	07	11	0	99241	25	1	100 00	1	Y	NPI	1213456789
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalestone, MD 01/01/07

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 9876543210 b. ZZ 400RT001X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)